Department of Health
Office of Emergency Medical & Trauma Prevention

SERVICE / VEHICLE RELICENSURE APPLICATION

Service Name: _____ / _____
(Legal Name) *(Also Known As)*

Address: _____ EMS Agency/License #: _____

_____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

EMS Representative: _____ Phone: _____

E-Mail Address: _____ FAX: _____

NOTE: This application may NOT be used to upgrade or change your agency's type of service license. Please contact our office for the appropriate forms needed to apply for a service type other than what you currently hold.

TYPE OF SERVICE (choose one only): Ambulance (Transport) ☐ Aid Service (Non Transport) ☐

IF YOUR RESPONSE *AREA* AND/OR RESPONSE *TIMES* HAVE CHANGED SINCE YOUR LAST APPLICATION, PLEASE ATTACH A WRITTEN EXPLANATION TO THIS APPLICATION.

WOULD YOU LIKE TO CONTINUE YOUR VERIFIED STATUS? *Yes ☐ No ☐ N/A ☐

***IF 'Yes', WHAT IS THE HIGHEST LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS?** BLS ☐ ILS ☐ ALS ☐

ORGANIZATION TYPE: (check the one that ***best*** applies to your organization)

Private for profit	☐	Fire District	☐	Law Enforcement	☐
Private non-profit	☐	City Fire Dept.	☐	Municipal (city/county)	☐
Private volunteer association	☐	Industrial Fire Dept.	☐	Search & Rescue	☐
Hospital District	☐	City/Fire Dist. Comb	☐	Other (*please specify below*)	☐
EMS District	☐	Federal Fire Dept.	☐	_____	

VEHICLES: Please provide the **number** of each type vehicle you are licensing (from Page 2):

Ground Ambulance ☐ Aid Vehicle (Non-Transport) ☐

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year**:**

Primary Responses ☐ Transports Primary/Secondary ☐
Secondary Responses ☐ Interfacility Transports *Only* ☐

PERSONNEL STATUS: Are your EMS personnel primarily: (*check one*) Paid ☐ Volunteer ☐

DO NOT DUPLICATE

SERVICE / VEHICLE RELICENSURE APPLICATION

EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all vehicles to be licensed. Vehicle location is the **address** in which the vehicle is ***physically located.*** Indicate the *type* of vehicle(s): AMB = ambulance; AID = aid vehicle (as defined in RCW 18.73.030). **Please check to see that each licensed vehicle has a license sticker appropriately displayed in the window. If there is no sticker, request one below.**

Please review WAC 246-976-260 through 390 to ensure your vehicles meet all requirements. WAC 246-976-300 requires all licensed vehicles to carry extrication equipment. A variance from this requirement may be requested, and if approved, the extrication equipment must be available within 10 minutes. To request a variance, indicate the **name** of the agency(s) providing extrication equipment below and enter 'Yes' next to the appropriate vehicles.

Agency(s) providing extrication equipment:_____

YEAR	MAKE AND MODEL	LICENSE PLATE NUMBER	ACTUAL ADDRESS OF VEHICLE *(If Different From Page 1)*	Choose One (✓)		STICKER NEEDED (Yes or No)	VARIANCE *For Extrication Equipment* (Yes or No)
				AMB	AID		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10							

Attach extra sheets as necessary, including all the required information.

NOTE: When *adding, removing*, or *changing* the location of licensed vehicles, it is always necessary to notify the Department of Health of the change(s). Contact the appropriate licensing office, at the address or telephone number below, to request a **"VEHICLE CHANGES APPLICATION."**

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SERVICE / VEHICLE RELICENSURE APPLICATION
GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the Regional Plan, and approved Regional Patient Care Procedures. *(Please find this information on our website at **www.doh.wa.gov/hsqa/emtp** **click on "Licensure Processes."** If you require hard copies of this information, please contact the appropriate Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. **Dispatch plan**

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2. **Response plan**

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3. **Response area**

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4. **Type of transport (emergency and/or interfacility), if any**

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5. **Tiered response and rendezvous, if any**

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6. **Back-up plan to respond (may not apply to agencies doing interfacility transports only)**

NOTE: Other services involved in your response plan must be informed by you that they are participants and identified in number 6 above. These agencies must agree to that participation. Attach extra sheets as necessary.

"I hereby affirm and declare that the information provided on this application is true and correct, and that:

1. *We operate in a manner that is consistent with the Regional Plan and pre-hospital patient care procedures;*
2. *The vehicles identified on Page 2 meet the minimum equipment requirements for the type of licensure and/or verification requested by our service;*
3. *We meet the minimum staffing requirements for licensure and/or verification as identified on the attached page;*
4. *Our EMS Personnel utilize DOH approved Medical Program Director (MPD) protocols; and*
5. *We maintain current liability insurance coverage."*

Person Completing Application ***(Please Print)*** **Date**

Owner/Operator ***(Signature & Title)*** **Date**

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